

FILED FEB 5 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1833

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 35

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MARION</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>ILLINOIS</u><br>b. COUNTY _____ |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>HANNIBAL</u>   |                                  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>QUINCY</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LEVERING HOSPITAL</u>  |                                  | d. STREET ADDRESS (If rural, give location)<br><u>1217 MAIN ST.</u>  |   |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>HARRY</u><br>b. (Middle) <u>CARL</u><br>c. (Last) <u>KREICH</u>   |                                  | 4. DATE OF DEATH<br>(Month) <u>1</u> (Day) <u>28</u> (Year) <u>1951</u>  |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>   | 8. DATE OF BIRTH<br><u>1890</u><br><u>FEBRUARY 18</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><u>60</u>          |
| 11. BIRTHPLACE (State or foreign country)<br><u>QUINCY ILL.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13a. FATHER'S NAME<br><u>CHARLES KREICH</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>MINNIE OEHLMAN</u>   |   |
| 14. NAME OF HUSBAND OR WIFE<br><u>ESTHER KREICH</u>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                             |   |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT'S SIGNATURE OR NAME<br><u>MRS. ESTHER KREICH</u><br>ADDRESS <u>QUINCY ILL.</u>   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |                                  |  |   |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Infarction</u>   |                                  |  |   |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Myocardial Infarction</u><br>DUE TO (c) <u>Spontaneous Coronary Thrombosis</u>   |                                  |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>4201</u>  |                                  |  |   |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)  |                                  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |                                  |  |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |   |
| 21f. HOW DID INJURY OCCUR?  |                                  |  |   |
| 22. I hereby certify that I attended the deceased from <u>Jan. 19</u> , 19 <u>51</u> , to <u>Jan. 20</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan. 20</u> , 19 <u>51</u> , and that death occurred at <u>2:40 A.M.</u> , from the causes and on the date stated above. |                                  |  |   |
| 23a. SIGNATURE<br><u>Wm. L. Lusk</u><br>(Name or title)   |                                  | 23b. ADDRESS<br><u>1001 Broadway</u>   |   |
| 23c. DATE SIGNED<br><u>1/29/51</u>  |                                  |  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>   |                                  | 24b. DATE<br><u>1-28-51</u>  |   |
| 24c. NAME OF CEMETERY OR CREMATORY<br><u>St. Francis</u>  |                                  | 24d. LOCATION (City, town, or county) (State)<br><u>Quincy Illinois</u>  |   |
| DATE REC'D BY LOCAL REG.<br><u>1-30-51</u>  |                                  | REGISTRAR'S SIGNATURE<br><u>Wm. L. Lusk</u>  |   |
| FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm. Crawford Smith</u>   |                                  | ADDRESS<br><u>Hannibal Mo</u>  |   |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED FEB 2 1951  
U.S. HEALTH DEPT.  
STATE FILED FEB 3 1951

APR 18 1951

DEC 11 1953

MAR 22 1951

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*W. Crawford Smith*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 3814

P. O. Address Hamlet, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.